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	152027	A. BUILDING 00 B. WING	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRA HOSPITAL OF FORT WAYNE	2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805

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S 0000 Bldg. 00	This visit was for a State hospital licensure survey. Dates: 7/16/2013 through 7/17/2013 Facility Number: 005007 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: claughlin 07/30/13	S 0000		
S 0264 Bldg. 00	410 IAC 15-1-4-1 GOVERNING BOARD 410 IAC 15-1.4-1 (a)(3) (a) The Governing Board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (3) Adopt bylaws and function			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	accordingly. Based on documentation review and interview, the facility's Governing Board failed to conduct quarterly governing board meetings to discuss Quality Assessment and Performance Improvement (APIA) as defined in the Vibra Hospital of Fort Wayne Governing Board Bylaws. Findings included: 1. Vibra Hospital of Fort Wayne Governing Board Bylaws (last approved 2/15/2011) Article III section 13 states, "Regular Meetings. At least four (4) regular meetings of the Governing Board shall be held each calendar year." The Governing Board Bylaws Article III Section 2 notes the Governing Board are to comply with all applicable laws and regulations. The regular board meetings will include, but not limited to: Appointment in the Medical Staff; Facility Plans and Budgets; Personnel Policies;	S 0264	Meetings of the Governing Board will occur in Quarter 3 and Quarter 4 of 2013 addressing: Credentialing, Quality PI Summary, Quality Summary for Contracted Services, Facility Budgets and Plans, Personnel Policies, and Operations. Review times will be scheduled for the remainder of 2014 going forward.CEO or Designee will be responsible for above plan. Meeting Minutes will demonstrate compliance and be reviewed at subsequent Governing Board Meetings.	08/31/2013

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	Professional Service Contracts; Quality Assessment and Performance Improvement; ..." 2. The Governing Board Meeting minutes were reviewed for the last two quarters of 2012 and the first 2 quarters of 2013. The regular Governing Board meetings for the previous 4 quarters were May 22, 2013 and September 7, 2012. The Governing Board had 1 other regular scheduled meeting in the first quarter of 2012. Therefore, the Governing Board did not have 4 regular meeting in the calendar year of 2012 and QAPI was not addressed quarterly by the Governing Board. 3. At 10:00 AM on 7/17/2013, staff member #2 confirmed the Ad Hoc Special Governing Board Meetings did not address QAPI issues and Professional Service Contracts. The special meetings only addressed physician credentialing and policy reviews.			

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S 0362 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F) (d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following: 6) Ensure that the hospital does the following: (A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants. Based on documentation review	S 0362	Education will be provided to Clinical Staff (RN and LPN) by	08/31/2013

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	and staff interview, the facility failed to notify Indiana Organ Procurement Organization (IOPO) for 1 hospital death in 2013. Findings included: 1. Hospital Procurement Agreement with IOPO signed in August, 2007; Article H section 2a states, "Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died in the Hospital." 2. Vibra Hospital Donation 2013 Statistics and Benchmarks report identified the hospital had 11 deaths in the first 6 months of 2013 and only 10 of those 11 deaths were reported to IOPO. 3. At 10:30 AM on 7/17/2013, staff member #2 indicated he/she contacted a representative with IOPO about the data that was furnished by IOPO on reported deaths. The staff member		IOPO Representative. Re-education will be provided for Routine Notification of Death by Vibra CCO or designee.DQM or Designee will audit for 100% compliance post mortality to ensure appropriate notification was provided.	

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	indicated the representative with IOPO stated a death in January 2013 was not reported to IOPO.			
S 0406 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and staff interview, the facility failed to ensure 14 services were part of its comprehensive quality assessment and improvement (QA&I) program: Anesthesia Services; CT Scanner; EEG; Endoscopy; Laundry; Maintenance; MRI; Neurosurgical Services; PET Scanner; Renal Dialysis; Speech Pathology; Surgical Service Inpatient; Transcription; and	S 0406	Contracted Services for Radiology (CT Scan, MRI, PET Scan, and ultrasound), EEG, Endoscopy, FAcility Maintenance, Laundry Services, Meurosurgical Services, Renal Dialysis, Speech Therapy, Surgical Services Inpatient, and Transcription wil be iincluded on 2013 Performance Improvement Plan. Each Service will be evaluated annually by the Hospital Leadership Team and recommendations will be provided to the MEC regarding improvements needed.DQM or Designee will update PI Plan and forward to MEC and GB for	08/31/2013

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	Ultrasound. Findings included: 1. Vibra Hospital of Fort Wayne 2013 Performance Improvement Plan implements all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. 2. The Quality Assessment/Performance Improvement Committee minutes were reviewed with staff member #2 for the previous complete 4 quarters. The minutes evidence 14 internal and contracted services were not being monitored the hospital's QAPI committee. The April 2013 committee minutes addressing Environmental of Care topic noted that the contracted service for preventive maintenance was to be monitored by the contracted service and was not the responsibility of Vibra Hospital of Fort Wayne. The 14 services		approval.	

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	included: Anesthesia Services; CT Scanner; EEG; Endoscopy; Laundry; Maintenance; MRI; Neurosurgical Services; PET Scanner; Renal Dialysis; Speech Pathology; Surgical Service Inpatient; Transcription; and Ultrasound. 3. At 12:00 PM on 7/16/2013, staff member #2 confirmed the Performance Improvement Committee did not monitor or evaluate 14 hospital services that are provided internally or through a contractual agreement.			
S 0556 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b) (b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.			

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	Based on personnel file review, policy and procedure review, manufacturer's directions, and interview, the facility failed to ensure TB testing/screening was performed according to policy for 15 of 17 staff members (#P1, P2, P3, P5, P6, P7, P8, P9, P10, P11, P12, P14, P15, P17, and P18). Findings included: 1. The personnel file for staff member #P1 indicated a TB test placed on 07/10/13 at 11:30 AM, but lacked a signature or name of the person performing the test. The form indicated the test was read on 07/12/13, but lacked a time to ensure it was read between 48-72 hours. 2. The personnel file for staff member #P2 indicated a TB test placed on 09/20/12 and read on 09/22/12, but lacked times to ensure it was read between 48- 72 hours. 3. The personnel file for staff member #P3 indicated the last TB test was placed on 08/08/11 and lacked documentation of a test since that time. 4. The personnel file for staff member #P5 indicated a TB test placed on 11/26/12 and read on 11/28/12, but	S 0556	Staff Certified to provide and read TB Skin Test will be provided re-education on appropriate documentation of the TB Skin Test including time palced and read. Employee Health Files will be reviewed for TB Skin Testing Compliance. Employees found to be non-compliant will have until 8/31/13 to rectify or will be removed from schedule.New Hire employees starting with August 2013 Orientation will be required to have proof of 2 Step TB skin test or will be provided with the 2 step test.Employee Health Nurse and HR or Designee will be responsible for compliance.Employee Health Nurse or Designee will monitor compliance for tb skin test monthly thereafter.	08/31/2013

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	lacked times to ensure it was read between 48- 72 hours. 5. The personnel file for staff member #P6, hired 05/29/13, indicated a first-step TB test placed on 04/21/12 and read on 04/23/12, but lacked times to ensure it was read between 48- 72 hours. The form also lacked documentation of a second-step TB test. 6. The personnel file for staff member #P7 indicated a TB test placed on 05/08/13 and read on 05/10/13, but lacked times to ensure it was read between 48- 72 hours. 7. The personnel file for staff member #P8 indicated a TB test placed on 09/18/12 and read on 09/21/12, but lacked times to ensure it was read between 48- 72 hours. 8. The personnel file for staff member #P9 indicated a TB test placed on 08/01/12 and read on 08/03/12, but lacked times to ensure it was read between 48- 72 hours. 9. The personnel file for staff member #P10, hired 04/10/13, indicated a first-step TB test placed on 04/09/13 at 4:30 PM and read on 04/12/13, but lacked a time to ensure it was read			

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	between 48- 72 hours. The form also lacked documentation of a second-step TB test. 10. The personnel file for staff member #P11, hired 04/24/13, indicated a first-step TB test placed on 04/24/13 and read on 04/26/13, but lacked times to ensure it was read between 48- 72 hours. The form also lacked documentation of a second-step TB test. 11. The personnel file for staff member #P12 indicated a TB test placed on 09/05/12 and read on 09/07/12, but lacked times to ensure it was read between 48- 72 hours. 12. The personnel file for staff member #P14 indicated a TB test placed on 09/20/12 and read on 09/22/12, but lacked times to ensure it was read between 48- 72 hours. 13. The personnel file for staff member #P15 indicated a TB test placed on 10/15/12 and read on 10/17/12 at 1600, but lacked a placement time to ensure it was read between 48- 72 hours. 14. The personnel file for staff member #P17 indicated the last TB test was placed on 10/03/11 and lacked documentation of a test since that time.			

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	15. The personnel file for staff member #P18 indicated a TB test placed on 09/17/12 and read on 09/19/12, but lacked times to ensure it was read between 48- 72 hours. 16. The facility policy "Tuberculin (TB) Skin Testing", last revised April 2011, indicated, "At the time of employment, during the initial Vibra Hospital immunization and screening evaluation, all new Vibra Hospital faculty/staff ...shall receive two (2) mantoux 5 Tu TB Skin Tests given two (2) weeks apart ("two step testing"). ... 1. Retesting will be conducted at least annually." 17. Manufacturer's directions for Aplisol, the testing solution, were to read the test 48 to 72 hours after placement. 18. At 9:30 AM on 07/17/13, staff member #A2 confirmed the personnel findings and indicated the facility did not follow their policy regarding two-step TB testing for new employees.			
S 0596 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii) (f) The hospital shall establish an infection control committee to monitor			

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	and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (iii) Cleaning, disinfection, and sterilization. Based on observation, interview, and manufacturer's directions, the infection control committee failed to ensure that health care equipment was disinfected in a clean environment and the patient care areas were adequately cleaned and the glucometers were adequately disinfected. Findings included: 1. At 1:58 PM on 7/17/2013, the soiled utility room on the 5th floor was inspected. The door to the room had a 'Biohazard' label posted on it. In the room were 8 empty red biohazard large containers and 3 in-use covered large biohazard containers. The room was also	S 0596	The Respiratory Therapy department will establish a dirty area in the Soiled Utility Room and a clean area in the Clean Utility Room. The RT will take dirty equipment to the soiled utility room (Designated area will be directly inside door) and scrub/clean the equipment as per manufacturers recommendations. After initial cleaning, the equipment will be placed in the appropriate solution to soak for designated time. Once soak is complete for high level disinfection, it will be rinsed and placed in a closed container. The closed container will be immediately transported to the Clean Utility Room. The equipment pieces will be placed in the appropriate place for drying. The container will be cleaned and appropriately stored. Once dried per manufactuers recommendations the pieces will be stored appropriately and put away.The Lead RT or Designee will observe the process a	08/31/2013

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	observed storing a cart of soiled laundry. In the rear of the room was a counter with a double bay sink. On the counter was a plastic covered container with yellowish liquid in the container. Inside the container was parts of equipment soaking in the solution. Next to the container was a clipboard noting the container contained respiratory equipment parts soaking in high-level disinfecting solution. 2. At 2:30 PM on 7/17/2013, staff member #17 indicated the 'Vela parts and/or Laryngoscope Blade' are rinsed off in the sink next to the plastic container containing peroxide high-level disinfectant solution. 3. During the tour of the patient care unit at 1:20 PM on 07/17/13, accompanied by staff member #A3, the following observations were made: A. The top surface and suction machines on the 2 emergency crash carts were coated with a layer of		minimum of 1 time weekly x 4 weeks for appropriate procedure. Once stabilization is achieved, quarterly monitoring wil begin.EVS Manager will educate the EVS staff on appropriate technique for cleaning the Crash Cart. EVS will clean items on the top of the crash car once daily. The duty is added to the housekeeping checklist.The EVS Manager has established a checklist for terminally cleaned rooms. eVS staff will be re-educated on proper technique for terminally cleaninig a room to ready it for a new admission. EVS Manager will audit terminally cleaned rooms prior to new admission iin the room using the checklist developed.EVS Manager or designee will audit 100% of terminally cleaned rooms 5 days per week until 100% compliance is established in one months time, at that time audits will continue for 90 days to ensure stabilization. and random audits thereafter. Clinical Staff will be re-educated on manfacturer's directiosn for the Purple top Sani-Wipes by CCO or Designee. After education, an Audit will be performed by verbally questionsing random staff weekly during Leadership Rounding, audits will continue 90 days post stabilization of 90% compliance. CCO or designee will ensure compliance.	

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	dust. B. The overbed table in room 551 was visibly soiled and sticky and a soiled plastic measuring container was sitting on the back ledge of the toilet. The room had been terminally cleaned and was ready for a new patient admission. C. Room 512, also ready for a new admission, was found with dusty wall ledges and suction canister. The inside of the night stand drawer was visibly soiled and sticky to touch. 4. At 1:40 PM on 07/17/13, staff member #A16, a nurse on the unit, indicated the Super Sani-cloth wipes were used to disinfect the glucometer between patients. He/she indicated the wipe was used and the glucometer was allowed to air dry which took 1- 5 seconds. 5. Manufacturer's directions for the Super Sani-cloth wipes indicated the surface/equipment/device needed to remain wet for 2 minutes for			

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	152027	A. BUILDING 00 B. WING	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRA HOSPITAL OF FORT WAYNE	2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805

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	adequate disinfection.			
S 0610 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation and documentation review, the facility failed to ensure high-protein enteral tube-feeding supplements were stored properly in the	S 0610	Enteral feedings stored in the Pharmacy will have a cover placed over them to protect them from light. Director of Pharmacy or Designee will be responsible to ensure compliance of above plan. EOC Rounds will include	08/31/2013

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	152027	A. BUILDING 00 B. WING	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRA HOSPITAL OF FORT WAYNE	2200 RANDALLIA DRIVE 5TH FLOOR FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Pharmacy Department. Findings included: 1. At 1:30 PM on 7/17/2013, the Pharmacy Department was observed storing Abbott enteral feeding supplements on wired shelves under florescent ceiling lights. The wire shelves contained at least 135 clear plastic single units of assorted type. The labels on all the bottles indicated the single bottles contained light sensitive nutrients 2. The manufacturer Abbott product label of the assorted enteral ready-to-eat nutritional supplements states, "Contain light sensitive nutrients." The manufacture indicates artificial light degrades vitamins such as riboflavin (B2), B6, and vitamin A. Vitamins losses occur gradually at low light exposure and faster in bright light. The manufacturer states, "Store product in the shipper or store on covered shelves or in		monitoring of same.	

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	close cabinet prior to use."			
S 0748 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(3) (e) All entries in the medical record shall be: (3) authenticated and dated promptly in accordance with subsection (c)(3). Based on policy and procedure review, medical record review, and interview, the facility failed to ensure all entries in the medical records were authenticated and dated according to policy for 13 of 18 records reviewed (#N2, N4, N5, N6, N7, N8, N9, N11, N12, N13, N14, N15, and N18). Findings included: 1. The facility policy "Physician's Orders", last revised 03/11, indicated, "1. All orders for patient care are written or pre-printed on the 'Physician's Order Sheet.' ...Transcription of Orders: The order is signed off in red ink and entered and a copy is made to give to licensed staff member treatment record by the charge nurse. It is to be countersigned and acknowledged on the Physician's order sheet by a Registered Nurse or	S 0748	Unit Clerks, RNs and LPNs wil be re-educated by CCO or designee on the Vibra Policies "Physician Orders", "Medical Record Documentation Requirements", and "Restraints".Audits will be completed by night shift 5 days per week until substantial Compliance is achieved on the following: Physician Pre-Printed and Verbal Orders are noted as transcribed per the policy, Restraint orders are appropriate to the need and the policy, Discharge Orders are noted as transcribed per policy. All are dated and timed by staff. Random audits will continue post substantial compliance.MEC will review the following policies: "Physician Orders", "Medical Record Documentation Requirements", and "Restraints". HIM manager or Designee will track and trend compliance for dating and timing and report QAPI and MEC.	08/31/2013

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	Vocational Nurse. Each must not the date, time, and title after their full signature." 2. The facility policy "Medical Record Documentation Requirements", last revised March 2013, indicated, "7. All entries into the medical record must be legible, signed, dated, and timed. ...b. Restraint orders must be authenticated within 24 hours by the prescribing physician." 3. The facility policy "Restraints", last revised 03/11, indicated, "c. Orders for restraint must specify the reason for the restraint, the type of restraint, the extremity or body part(s) to be restrained and the duration (time frame) for restraint application. ...a restraint must never be written as a standing order on an as-needed basis (i.e., PRN)." 4. The medical record for patient #N2 indicated pre-printed physician orders from 01/23/13, 01/24/13, and 01/25/13 that were not noted as transcribed by a nurse. The record also contained a pre-printed restraint order sheet, completed by a nurse on 01/18/13, but with no date or time with the physician's signature. 5. The medical record for patient #N4			

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	indicated a pre-printed physician order from 03/01/13 that was not noted as transcribed by a nurse. The record also indicated verbal orders that were not noted as transcribed by a nurse. A telephone order written by a nurse at 0150 on 03/08/13 indicated, "Restrain prn". 6. The medical record for patient #N5 indicated pre-printed physician orders and telephone orders from 02/14/13 that were not noted as transcribed by a nurse. 7. The medical record for patient #N6 indicated pre-printed restraint orders from 12/03/12, 12/04/12, 12/05/12, 12/06/12, 12/08/12, 12/14/12, and 12/17/12 that were not timed by the physician or noted as transcribed by a nurse. 8. The medical record for patient #N7 indicated written physician discharge orders from 12/30/12 that were not noted as transcribed by a nurse. 9. The medical record for patient #N8 indicated pre-printed restraint orders from 03/13/13, 03/16/13, 03/17/13, 03/20/13, 03/21/13, 03/22/13, 03/23/13, 03/24/13, 03/25/13, 03/26/13, and 04/01/13 that were not timed by the physician or noted as transcribed by a			

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	nurse. 10. The medical record for patient #N9 indicated pre-printed admission orders that were not timed or dated by the physician or noted as transcribed by a nurse. 11. The medical record for patient #N11 indicated a pre-printed physician order from 02/04/13 and written orders from 02/05/13 that were not noted as transcribed by a nurse. 12. The medical record for patient #N12 indicated pre-printed admission orders that were not timed or dated by the physician or noted as transcribed by a nurse and written physician orders from 04/24/13 and 04/29/13 that were also not noted by the nurse. 13. The medical record for patient #N13 indicated pre-printed physician orders from 02/18/13 that were not noted as transcribed by a nurse and written physician orders from 02/16/13, 03/02/13, and 03/05/13 that were also not noted by the nurse. 14. The medical record for patient #N14 indicated a written physician transfer order from 05/03/13 that was not noted as transcribed by a nurse.			

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	15. The medical record for patient #N15 indicated a preprinted restraint order from 05/26/13 that lacked documentation of physician notification, a physician signature, or notation as transcribed by a nurse. 16. The medical record for patient #N18 indicated pre-printed admission orders from 03/01/13 that were not noted as transcribed by a nurse and written physician orders from 05/02/13 that were also not noted by the nurse. 17. At 12:10 PM on 07/17/13, staff member #A2 confirmed the medical record findings and nonadherence to policy.			
S 0754 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (5) Evidence of appropriate informed			

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	consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law. Based on policy review, medical record review, and interview, the facility failed to ensure all patient records contained an appropriately executed Consent for Treatment and/or other documents requiring consents in 5 of 18 medical records reviewed (#N3, N5, N7, N11, and N17). Findings included: 1. The facility policy "Patient Consent for Treatment", effective 04/27/11, indicated, "It is the policy of Vibra Hospital that a patient consent for treatment/surgery shall be obtained according to the established recommendations of the State of Indiana and pursuant to the state, federal and regulatory standards for informed consent. ...10...Signature and professional designation of person witnessing consent." 2. The medical record for patient #N3 indicated a "Consent to Treat, an "Acknowledgment of Receipt of Health Care Information", and a "Consent for Photograph and/or Filming" that were	S 0754	RNs and LPNs will be re-educated on policy "Patient Consent for Treament", to ensure understanding of Witness Signature requirements.Charge Nurse Audit will include daily chart audits for witness signatures on all consents. Director of Case Management or Designee will audit 100% of new patient charts for completed consents until stabilization is reached and then random audits will continue to be completed by Case Management for continued compliance.	08/31/2013

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	signed by a power of attorney for the patient, but not signed, dated, or timed by a witness in the spaces provided. 3. The medical record for patient #N5 indicated a "Consent to Treat, an "Acknowledgment of Receipt of Health Care Information", and a "Release of Liability from Safety Devices and/or Falls Prevention Protocol" that were signed by a family member, but not signed, dated, or timed by a witness in the spaces provided. 4. The medical record for patient #N7 indicated a "Consent to Treat, an "Acknowledgment of Receipt of Health Care Information", and a "Release of Liability from Safety Devices and/or Falls Prevention Protocol" that were signed by a family member, but not signed, dated, or timed by a witness in the spaces provided. 5. The medical record for patient #N11 indicated a "Consent to Treat, an "Acknowledgment of Receipt of Health Care Information", and a "Consent for Photograph and/or Filming" that were signed by the patient, but not signed, dated, or timed by a witness in the spaces provided. 6. The medical record for patient #N17			

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	indicated a "Consent to Treat, an "Acknowledgment of Receipt of Health Care Information", and a "Consent for Photograph and/or Filming" that were signed by a family member, but not signed, dated, or timed by a witness in the spaces provided. 7. At 3:10 PM on 07/16/13, staff member #A2 confirmed the medical record findings and indicated there was no other consent policy, but confirmed all of the consents should be witnessed and complete.			
S 0762 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(13) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (13) A discharge summary authenticated by the physician. A final progress note may be substituted for the discharge summary in the case of a normal newborn infant and uncomplicated obstetric delivery. The final progress note should include any instruction given to the patient and family. Based on review of the Medical Staff Rules and Regulations, policy and procedure review, medical record review, and interview, the facility failed to ensure	S 0762	Review of Hispital medical Staff Rules and Regulations Section 11 concerning Discharge Summaries and FAcility Policy "Medical Record Documentation	08/31/2013

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	all medical records for patients hospitalized for greater than 48 hours contained a timely discharge summary for 11 of 18 (#N2, N4, N5, N6, N7, N8, N10, N13, N14, N16, and N18) records reviewed. Findings included: 1. The facility's 2010 Medical Staff Rules and Regulations indicated, "11. A discharge summary shall be written/dictated on all medical records of patients hospitalized over 48 hours. All discharge summaries shall be authenticated by the responsible practitioner. 2. The facility policy "Medical Record Documentation Requirements", last revised March 2013, indicated, "7. All entries into the medical record must be legible, signed, dated, and timed. ...21. All entries in the medical record shall be legible dated and authenticated. Authentication of an entry requires the use of a unique identifier. ...31. Medical Records will be complete within 30 days of the patient's discharge." 3. The medical record for patient #N2, who was admitted 01/04/13 and expired 01/26/13, indicated a discharge summary dictated 03/03/13, greater than 30 days		Requirements" will be completed in MEC. HIM Manager or Designee will track and trend complaince and report to QAPI and MEC.	

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	later, with no date or time with the physician's signature. 4. The medical record for patient #N4, who was admitted 03/01/13 and expired 03/08/13, indicated a discharge summary dictated 04/14/13, greater than 30 days later, with no date or time with the physician's signature. 5. The medical record for patient #N5, who was admitted 01/23/13 and expired 02/15/13, indicated a discharge summary dictated 03/22/13, greater than 30 days later, with no date or time with the physician's signature. 6. The medical record for patient #N6, who was admitted 11/27/12 and discharged 12/24/12, indicated a discharge summary dictated 01/29/13, greater than 30 days later, with no date or time with the physician's signature. 7. The medical record for patient #N7, who was admitted 12/11/12 and discharged 12/31/12, indicated a discharge summary dictated 01/31/13, greater than 30 days later, with no date or time with the physician's signature. 8. The medical record for patient #N8, who was admitted 03/12/13 and discharged 04/08/13, indicated a			

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	discharge summary dictated 05/26/13, greater than 30 days later, with no date or time with the physician's signature. 9. The medical record for patient #N10, who was admitted 02/25/13 and discharged 03/16/13, indicated a discharge summary dictated 04/30/13, greater than 30 days later, with no date or time with the physician's signature. 10. The medical record for patient #N13, who was admitted 02/14/13 and discharged 03/08/13, indicated a discharge summary dictated 04/27/13, greater than 30 days later, with no date or time with the physician's signature. 11. The medical record for patient #N14, who was admitted 03/25/13 and transferred 05/03/13, lacked a discharge summary, over two months later. 12. The medical record for patient #N16, who was admitted 03/18/13 and discharged 04/26/13, indicated a discharge summary dictated 05/27/13, greater than 30 days later, with no date or time with the physician's signature. 13. The medical record for patient #N18, who was admitted 02/28/13 and discharged 05/22/13, lacked a discharge summary, almost two months later.			

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	14. At 12:10 PM on 07/17/13, staff member #A2 confirmed the medical record findings and nonadherence to policy.			
S 0812 Bldg. 00	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (a)(4)(A)(B)(C)(D)(E)(F)(G)(H)(I)(J)(K) (a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following: (4) Maintain a file for each member of the medical staff that includes, but is not limited to, the following: (A) A completed, signed application. (B) The date and year of completion all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable. (C) A copy of the member's current Indiana license showing the date of licensure and current number or an available certified list provided by the health professions bureau. A copy of practice restrictions, if any, shall			

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	be attached to the license issued by the health professions bureau through the medical licensing board. (D) A copy of the member's current Indiana controlled substance registration showing the number, as applicable. (E) A copy of the member's current Drug Enforcement Agency registration showing the number,as applicable (F) Documentation of experience in the practice of medicine. (G) Documentation of specialty board certification, as applicable. (H) Category of medical staff appointment and delineation of privileges approved. (I) A signed statement to abide by the rules of the hospital. (J) Documentation of current health status as established by hospital and medical staff policy and procedure and federal and state requirements. (K) Other items specified by the hospital and medical staff. Based on documentation review, the facility failed to ensure that 2 of 4 physician's Delineation of Privileges were approved by the Medical Executive Committee (#10, 11). Findings included: 1. Medical Staff Bylaws of Vibra Hospital of Fort Wayne (last approved 2/2012) Article IV	S 0812	Review of Medical Staff Bylaws of Vibra Hospital of Fort Wayne Article IV Section 4.2 noting physician clinical privileges are to be reviewed and approved by the Medical Executive Committee will be completed in MEC.Credentialing Specialist or designee will reivew each request prior to the meeting of the Medical Executive Committee to assure proper approval/denial is granted by the MEC. Post meeting, the Credentialing Specialist or designee will review all forms for proper signatures and approval/denials. This will serve as 100% audit.	08/31/2013

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	section 4.2 notes physician's clinical privileges are to be reviewed and approved by the Medical Executive Committee. 2. Physician staff member #10 Delineation of Privileges were signed by the physician seeking clinical privileges on 2/13/12. However, the Medical Director; Medical Executive Committee (Committee as a Whole); Chief Executive Officer; and Board of Directors did not sign his/her Delineation of Privileges for approval. 3. Physician staff member #11 requested 10 Specific Clinical Privileges - General Diagnostic/Therapeutic Interventions. Medical Executive Committee did not mark if the special requested procedures were approved or denied.			
S 0952 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152027	A. BUILDING 00 B. WING	07/17/2013

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	(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy and procedure review, medical record review, and interview, the facility failed to follow their established procedure for blood transfusion administration and physician orders in 3 of 4 patients who received blood on the patient unit (#N14, N15, and N16). Findings included: 1. The facility policy "Blood Product Administration", last revised 03/2012, indicated, "2. Obtain baseline vital signs immediately (within 1 hour) prior to transfusion and document. ...9. One RN must stay with patient for the first 15 minutes. 10..Document vitals and assessment at 15 minutes.. 12. document assessments every 30 minutes from transfusion initiation. ...G. Transfusion Reaction: ...increase or decrease in systolic blood pressure (change of 30 mm HG or more). 1. Place an asterix (*) next to any assessment items that are present, document under the patient care notes."	S 0952	CCO or designee will provide re-education to RNs and LPNs on "Blood Product Administration" with focus on appropriate baseline vital signs, timing of all entries including pre-transfusion vital signs, appropriate documentation of starting and stopping of transfusions and identification of possible Reactions.DQM or designee will complete 100% audits on Blood Transfusion for above education areas until stabilization is identified and continue 1 quarter after stabilization.	08/31/2013

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	2. The medical record for patient #N14 indicated a unit of blood was started at 2050 on 04/01/13 with a pre-transfusion blood pressure of 113/85 at 2020. The 15 minute blood pressure was documented as 190/98 at 2105, which was a change of greater than 30 mm HG. The record lacked any other documentation regarding this change in blood pressure. The patient had another unit of blood on 04/28/13 and the Transfusion Administration Record lacked a time for the pre-transfusion vital signs. 3. The medical record for patient #N15 indicated a unit of blood was started at 1010 on 06/01/13, but the Transfusion Administration Record lacked a time for the pre-transfusion vital signs. 4. The medical record for patient #N16 indicated physician orders from 9:15 PM on 03/19/13, "Type X match 2 units of PRBC [packed red blood cells] and transfuse each unit over 4 hours. Lasix 40 mg. [milligrams] IV [intravenously] at the end of each unit." The Transfusion Administration Record indicated the first unit was started at 0120 on 03/20/13 and ended at 0400, two hours and forty minutes later. The form also had the 15 minute vital signs documented as 0120, the same as the start time. The			

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	Medication Administration Record indicated the first dose of Lasix was given at 0400 on 03/20/13. Another Transfusion Administration Record indicated a second unit of blood was started at 0520 on 03/20/13 and ended at 0930. The Medication Administration Record lacked documentation that Lasix was given after the second unit. The medical record lacked any further documentation regarding the Lasix or the shorter transfusion time for the first unit. 5. At 12:10 PM on 07/17/13, staff member #N2 confirmed the medical record findings and nonadherence to policy and physician orders.			
S 1114 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(1) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (1) No condition in the facility or on the grounds shall be maintained which may be conducive to the harborage or breeding of insects, rodents, or other vermin. Based on documentation review and staff interview, the hospital	S 1114	Pest Control Service Inspection was completed on 5th Floor (Vibra Hospital) on 7/25/13.	08/31/2013

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	failed to ensure the environment was maintained to prevent harborage or breeding of insects, rodents, or other vermin. Findings included: 1. Lease Agreement between F1 and Vibra Hospital of Fort Wayne (signed September 2012) agreed that F1 will maintain the environment free from insects and rodents. 2. Vibra Hospital of Fort Wayne moved in the new facility within F1 on Jan 1st, 2013. F1's Pest Sighting Logs since 1/1/13 revealed CE1 has never treated Vibra Hospital of Fort Wayne. CE1 treated F1 and its grounds. CE1 conducted 51 reported sightings since 1/7/2012. 3. At 11:00 AM on 7/17/2013, F1's staff member #9 indicated the EVS Department will monitor the Vibra Hospital of Fort Wayne on pest control. All routine pest control inspections and pest sightings will be logged in the CE1 Pest Sighting Log book. CE1 visits F1 to conduct routine		There was not any activity found.Reports for Pest Control will be reported to the EOC who will report to Quality and MEC/GB as appropriate. Committee Minutes will demonstrate complaince. Safety Officer or Designee will be responsible for maintained compliance.	

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	treatments and pest sightings at least once a week on Monday of each week. 4. At 12:50 PM on 7/17/2013, F1's staff member #15 indicated he/she reviewed all pest control documents on file and discovered that Vibra Hospital of Fort Wayne has never been treated. F1 was responsible for treating Vibra Hospital of Fort Wayne.			